This form must be received by the Benefits Department within 31 calendar days of the qualified change in status or hire date, whichever is applicable.

Press Tab to begin filling out the form.

SF 4400-ADV # (2-2001)
Supersedes (1-2001) issue

UCI

☐ **Initial Enrollment** ☐ **Reinstatement from LOA** ☐ **Additions/Changes**

APPLICATION FOR SANDIA'S DENTAL & VISION CARE PLAN

Name (Last, First, Middle Initial)			Social Security Number	Union
Gender	Date of Birth	Sandia Hire Date	Business Phone Number	Home Phone Number
Address		City	State	Zip Code

Type of Coverage: (Employee Coverage)

☐ **DENTAL**
- ☐ **Single**
- ☐ **Family***
- ☐ **Decline**
- ☐ **Dependent of another Sandian****

☐ **VISION**
- ☐ **Single**
- ☐ **Family***
- ☐ **Decline**
- ☐ **Dependent of another Sandian****

*If you checked Family, please list your dependents below.
**If you are a dependent under another Sandian's dental and/or vision plan(s), please list their name and social security number here: _____

Dependents to be Insured

Eligible Dependents are defined in the applicable "Summary Plan Descriptions."

						FOR BENEFITS USE ONLY	
Spouse's Name		Sex M/F	Birth Date	Social Security Number		Effective Date	Cancel Date
Dependent(s) Name(s)	Relationship to Employee***	Sex M/F	Birth Date	Social Security Number	Full Time Student	Effective Date	Cancel Date
					☐Yes☐No		
					☐Yes☐No		
					☐Yes☐No		
					☐Yes☐No		

Note: If enrolling a handicapped dependent, call the Benefits Department (845-2363) for assistance.
***If a dependent is your stepchild, does this child reside in your home?

For Benefits Use Only:

SNL Database Updated: _____
Metlife-Dental Notified: _____
Cole-Vision Notified: _____

Reason for enrollment (ex: new hire, marriage, new baby, etc.) _____

Dental & Vision coverage effective date: _____

_____ _____
Employee Signature Date

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